SURGICAL ETHICS CHALLENGES

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To transfer or not to transfer, that is the question

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An elderly patient who underwent a complex emergency abdominal aneurysmectomy two weeks ago is in coma, ventilator dependent, and in severe multisystem organ failure with a deteriorating prognostic index score. The family has become increasingly hostile towards Dr S. Cold, the consultants, the ICU nurses, and the janitorial staff. An estranged wife has called once to defer decision-making to the children. Three children intermittently visit and are openly critical of the medical care. One child is an ICU nurse supervisor at a small local suburban hospital. Dr Cold spoke to the family yesterday about instituting DNR orders and discontinuing some supportive therapy that was not working. The family first required another consultation and then demanded that Dr Cold transfer the patient to the hospital where the daughter works. The hospital does not provide tertiary care. A physician there is willing to assume responsibility. How should Dr Cold respond?

A. Do as they request.
B. Refuse outright.
C. Call the accepting physician and explain why the case is futile.
D. Take the matter to the ethics committee to prevent transfer.
E. Call the wife and children to schedule an exploratory family conference and insist they come to a decision.

Impossibilium nulla obligatio est - Nobody has any obligation to the impossible.

Corpus Iuris Civilis

Deciding when to stop therapy has fewer guidelines than when to start, especially when the endpoint is death. Nothing in human experience is so certain to occur and as uncertain in its timing and consequences as death. Only two people mentioned in the Bible and a handful in Greek mythology escaped death. Victor Hugo, a most vivid litterateur, slaps us with the starkness that, ". . . wolves become lambs—such transformations occur in last agonies; tigers lick the crucifix; when the dark portal opens ajar," and further, "a corpse is a pocket which death turns inside out and empties." It is no surprise that patients and their families with acute illnesses, absent protracted suffering, want everything possible to be done.

In response to such requests, physicians should keep very much in mind that they have not only the right to refuse to provide what they justifiably judge to be inappropriate therapy; they have the professional duty to exercise good judgment about what not to do. The clinical ethical concept of futility concept is a useful guide for making such decisions.[1] Futility has an interesting etymology. From a Latin root, it first meant to "pour forth" with the recognition that "those who talk the most have the least worth saying", as used in the time of Francis Bacon. It then came to mean "leaky" as in a "leaky boat."[2] Everyone knows that to go to sea in a leaky boat is futile, if one's desired outcome is to traverse the sea, not sink beneath it. In clinical settings, futility means that there is a reliable expectation that the outcome toward which clinical intervention aims will not occur. To be clinically applicable, this general ethical concept of futility must be specified with respect to outcomes. There are four main senses of futility, each related to a specific outcome:

1. "Physiologic futility" is when the intervention is reliably expected not to produce its desired physiologic outcome, and Dr Cold's patient may be progressing to physiologic futility.
2. "Overall futility" reflects a reliable expectation that the intervention will not restore the patient's capacity to interact with the environment and continue human development.
3. "Imminent demise futility" characterizes a reliable expectation that the patient will die before discharge and not recover interactive capacity before death, as may be the case with our elderly aneurysm patient.
4. "Quality of life futility" applies when the patient's current or projected condition will result in an unacceptable quality of life judged from the patient's perspective.

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Competition of interest: none.
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Simply put, it applies when an intolerable inability to engage in or derive pleasure from life exists.

The attending surgeonhas reached the stage of prognostic discouragement because of imminent-demise futility and a continuingly deteriorating physiology that is progressing toward physiologic futility.

The repeated reproaches from this family worsen the surgeon's objectivity, which is sorely needed. Extrapolating the future outcome under pressure, in such cases, can lead to giving up prematurely or giving in to requests for unindicated therapy can phase into futile treatment.

As mentioned in a previous paper, physicians need to be aware that lay family members engage strong denial mechanisms when faced with the prospect of their loved one's death.[3] Almost nine out of ten family members of critically ill patients doubted the physician's prognosis when it was death. There are further end-of-life differences by race.[4]

Surgeons who perform high-risk procedures on seriously ill patients experience end-of-life situations many times over the years and may fail to appreciate the emotional turmoil for the patient's family when an unexpected death takes place. We know of a famous world-renowned surgeon (not at Baylor) who when faced with such a discouraging case simply stopped personally going to see the patient or his family. Another equally renowned surgeon—when an operating-room death occurred—dispatched the most junior resident to the waiting room to inform the waiting family members. Are these examples rare or do we all tend to withdraw emotionally, if not physically, from professional pain when the limits of surgery to prevent death are approached or reached, as in this case?

In the Code of Professional Conduct written in 2003, two of the nine professional responsibilities apply to the present case: encompass within our surgical care the special needs of terminally ill patients and acknowledge and support the needs of patients' families.[5] Terminal illness is not restricted to cancer patients. Properly applied, the surgical ego multiplies the ability to accomplish Herculean tasks but one must take care that it does not continue on cruise control when things get out of control. Now the patient care is beyond Dr Cold's control and perhaps also the family's good will.

When things get out of control and the limits of surgery to alter the inevitable course of life-taking disease are approached or reached, the surgeon has an ethical obligation to prevent the patient from receiving inappropriate care within the boundaries of vested authority. Dr Cold has a fiduciary obligation to protect this patient from inappropriate overtreatment at his institution and to inform a colleague at the receiving hospital of his beliefs.

Choice B has no ethical or legal basis. Patients' surrogates have the moral and legal right to decide therapy unless it can be shown that their choices are not what the patient would have chosen or that the therapy requested was clearly inappropriate. The latter applies here, and outright refusal is no substitute for the sensitive and challenging conversation that must occur about the limits of surgery to alter the inevitable outcome in this case. Moreover, outright refusal is egregiously disrespectful of a family in stress.

But don't you have the duty to prevent your patient from receiving inappropriate care regardless of the hospital to which he is being admitted, especially if he is being admitted to a hospital with inadequate facilities for his condition? Duty is an overused, under-defined word. Duties are behaviors that are essential to the functioning of a society, organization, or cause that would likely not be done without enforcement. Paying taxes, obeying military orders, or obtaining medical licensure are examples of duties. Preventing what you consider excessive treatment is a largely unrecognized, unenforced duty.

Thus, choice A skirts responsibility to the patient and, worse, turfs a poorly managed ethical challenge to another, perhaps unsuspecting, colleague who will almost certainly and quickly reach the same clinical ethical judgments as Dr Cold should about imminent-demise and physiologic futility. No service is done to the patient or the patient's family by kicking the can down the road.

Choices C and D are attempts to circumvent the family's decision. Like Choice B, they are no substitute for the frank conversation that now needs, urgently, to occur.

Option E is the best choice. At the family conference, Dr Cold should explain that everything that should have been done for this patient was done and that, despite a sustained and aggressive response to his disease, the limits of surgical and medical intervention are nearing. Dr Cold should use lay language to explain futility concepts and the importance of having been involved during the course of the illness. Also, it is important to have expert tertiary care which could be added when indicated. Therefore, transfer to another hospital is not in the patient's interest. All involved in patient's care hovering in the twilight zone between life and death have ethical obligations to tailor care to administer what is needed, but to avoid inappropriate over-treatment, including the patient's family members.

Dr Cold must convince the family to allow proper care or relinquish authority. Dispensing unindicated medical therapy is anti-professional, regardless of rationalization.

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